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May 26, 2016

VIA HAND DELIVERY

Ruby Potter, Administrator
Maryland Health Care Commission
Center for Health Care Facilities
Planning & Development
4160 Patterson Avenue
Baltimore, MD 21215

Re: Anne Arundel Medical Center Certificate of Need Application –
Anne Arundel Medical Center Mental Health Hospital

Dear Ms. Potter:

Enclosed are six copies of the Applicant's Responses to the Completeness Questions dated May 3, 2016 for filing in the above-referenced case.

Should you have any questions, please let me know. Thank you for your attention to this matter.

Sincerely,

Marta D. Harting

MDH:rlh
Enclosures

ANNE ARUNDEL MEDICAL CENTER

MENTAL HEALTH HOSPITAL

APPLICANT'S RESPONSES TO

MAY 3, 2016

COMPLETENESS QUESTIONS

May 26, 2016

PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. The application identifies Anne Arundel Health System, Inc. as the owner, and Anne Arundel Medical Center as the applicant (in Part I), despite the fact that this will not be part of the hospital, but instead be licensed as a special hospital – psychiatric. In Part III, #2 of the application, the applicant is described as Anne Arundel Health System, Inc. Please explain the apparent inconsistency. An organizational chart showing where the proposed AAMC Mental Health Hospital will reside within the organizational structure of Anne Arundel Health System, Inc. might be helpful.

Applicant Response:

The owner is Anne Arundel Health System, Inc. (AAHSI) and the Applicant is AAHSI's wholly-owned subsidiary Anne Arundel Medical Center (AAMC). Part III #2 contains an incorrect reference to AAHSI as the Applicant. It should state that the Owner (Anne Arundel Health System, Inc., or "AAHSI") is the owner of Anne Arundel Medical Center (AAMC), an acute care general hospital. AAMC is the owner of Anne Arundel General Treatment Services, Inc. (the entity doing business as Pathways, a substance use treatment center).

Under COMAR 10.24.01.07D(1), AAMC will designate, Anne Arundel Mental Health Services, Inc., as a wholly owned subsidiary of AAMC, to be the intended licensee of the project. Please refer to **Exhibit 18** for an organizational chart that shows the placement of Anne Arundel Mental Health Services, Inc. in the corporate structure.

2. **Please reconcile the difference in the amount of shelled space reported in Table B (5,796 sq. ft.) with the approximately 6,500 sq. ft. in the *Shell Space Analysis* referenced on p. 77. If the latter is correct, please revise Table B accordingly.**

Applicant Response: Table B is correct. The Shell Space Analysis section on page 77 should state that there will be approximately 5,800 square feet of shell space on the first floor, and the associated fit out cost would be approximately $667,000.

3. **Please provide a legible set of project drawings at least to 1/16" scale. The floor plans for each floor should have all rooms labeled by purpose or function, room sizes, number of beds, location of bathrooms, nursing stations, and any proposed space for future expansions, with "shell space" labeled. For the site diagram, please show the current location of the Pathways program and the direction of AAMC in relationship to the new mental health hospital.**

Applicant Response: The requested drawings are attached as **Exhibit 19**. Additionally, a map showing the location of the AAMC in relationship to the new mental health hospital is attached as **Exhibit 20**.

PROJECT BUDGET

4. **Are the costs for installing micro-bio-retention facilities, a step pool storm conveyance system, and a county production well identified in Exhibit 6 included in the costs for Site Preparation? If not, please explain why.**

Applicant Response: The costs of the micro-bio-retention facilities and step pool storm conveyance system costs included. No costs associated with the County production well are included because this is a future County project unassociated with the proposed mental health hospital (i.e., it would not provide water to the project). Although it is not necessary to relocate the well to accommodate the mental health hospital, the County is considering whether it will relocate the well to another site, but no decision has been made at this time.

5. **Please show how the $550,000 in Contingency Allowance was calculated.**

Applicant Response:

Design	$	1,373,350		
Building / New Construction (MSV)	$	12,790,057		
Site & Infrastructure	$	1,361,073		
Permitting	$	23,757		
TOTAL NEW CONSTRUCTION			**$**	**15,548,237**
Movable Equipment	$	900,000		
TOTAL MOVABLE EQUIPMENT			**$**	**900,000**
Design Contingency @ 3.5 %	$	48,067		
Design Contingency Adjustment	$	1,933		
Construction Contingency @ 3.5 %	$	447,652		
Construction Contingency Adjustment	$	2,348		
Site & Infrastructure Contingency @ 3.5 %	$	47,638		
Site & Infrastructure Contingency Adjustment	$	2,362		
TOTAL CONTINGENCY ALLOWANCE			**$**	**550,000**
TOTAL CAPITAL COST			**$**	**16,998,237**

CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR 10.24.01.08G(3)

State Health Plan

6. **The "Continuity" standard – AP13 – states: "Facilities providing acute psychiatric care shall have written policies governing discharge planning and referrals between the program and a full range of other services including inpatient, outpatient, long-term care, aftercare treatment programs, and alternative treatment programs."**

   Your response states that: "At discharge, patients admitted to the mental health hospital will be referred to an appropriate array of clinical and support programs to ensure continuity of care and continued stabilization," and references Exhibit 17 (the relevant policy, "Treatment/Discharge"). However, a reading of the policy appears to show that it speaks to treatment planning and execution, but does not reference discharge procedures. Please address this.

Applicant Response: Please refer to the Discharge Policy attached as revised **Exhibit 17** (to replace existing Exhibit 17) which contains the discharge procedures that will be followed.

7. **Standard AP14 requires letters of acknowledgement from: the local and state mental health advisory council(s); the local community mental health center(s); the Department of Health and Mental Hygiene; and the city/county mental health department(s). The application contains an impressive collection of letters supporting the application, but does not include letters from the prescribed organizations.**

Applicant Response: Please refer to Exhibit 21 for a letter of acknowledgment from the Secretary of the Department of Health and Mental Hygiene. Appendix 3(c) to the Application includes a letter of support for the Application from the Anne Arundel County Health Department. Additionally, Appendix 3(c) includes a letter of support for the Application from the Anne Arundel County Mental Health Agency, Inc. (AACMHA), the County's local behavioral health authority established under State law (§§10-1201 – 1203 of the Health-General Article) and enabled by County Ordinance (Article 2, §2A-102). AAMC is aware of no other local governmental or quasi-governmental mental health agencies in Anne Arundel County.

Need

8. **Please list the CSS[1] codes used to define mental health conditions on Charts 1 and 2.**

Applicant Respponse: For purpose of evaluating the overall demand for mental health inpatient volume (defined to exclude substance use-related disorders and alcohol-related disorders), the following CCS codes were applied:

Clinical Classifications Software for ICD-10 codes ("CCS codes")

CCS_Level_1		CCS_Level_2	
MULTI CCS LVL 1	MULTI CCS LVL 1 LABEL	MULTI CCS LVL 2	MULTI CCS LVL 2 LABEL
5	Mental Illness	5.1	Adjustment disorders [650]
5	Mental Illness	5.2	Anxiety disorders [651]
5	Mental Illness	5.3	Attention deficit conduct and disruptive behavior disorders [652]
5	Mental Illness	5.4	Delirium dementia and amnestic and other cognitive disorders [653]
5	Mental Illness	5.5	Developmental disorders [654]
5	Mental Illness	5.6	Disorders usually diagnosed in infancy childhood or adolescence [655]
5	Mental Illness	5.7	Impulse control disorders not elsewhere classified [656]
5	Mental Illness	5.8	Mood disorders [657]
5	Mental Illness	5.9	Personality disorders [658]
5	Mental Illness	5.10	Schizophrenia and other psychotic disorders [659]
5	Mental Illness	5.11	Alcohol-related disorders [660]
5	Mental Illness	5.12	Substance-related disorders [661]
5	Mental Illness	5.13	Suicide and intentional self-inflicted injury [662]
5	Mental Illness	5.14	Screening and history of mental health and substance abuse codes [663]
5	Mental Illness	5.15	Miscellaneous mental disorders [670]

Excluded from the summary of acute mental health volume in the AAMC application

This definition was adopted to prepare high level market analyses, including utilization trends and market share analyses. For purposes of this application, the definition for mental health volume excluded substance use-related disorders and alcohol-related disorders.

[1] Original question referred to "CSS codes" but the classification system used was the "CCS" classification system. These codes are defined above, and can be mapped to ICD-9 codes.

9. **Please explain how the need explanation beginning on p. 36 calculates to the volume of inpatients reported on Table I. Perhaps showing the math would be helpful.**

Applicant Response: The following information clarifies that the narrative beginning on page 36 documents **current experience at AAMC** and represents one approach to documenting need, while Table I reflects the more rigorous, conventional approach to projecting actual volume with a **use rate/market share projection model:**

Current experience at AAMC: Transfer volume as evidence of community need (page 36-37)

Beginning on page 36, AAMC documents "Evidence of Community Need" as reflected in many different indicators. Most prominently (and most pressing) is the number of patients who present in AAMC's Emergency Department and who require transfer to an inpatient psychiatric unit at another hospital (Total = 946 "AAMC-eligible" patients, i.e. **946 patients** who could have been served by the proposed AAMC unit).

This figure provided a firm basis for planning a 16-bed unit projected to operate at 90+% occupancy beginning in Year 1. Even if one were to assume that AAMC retained only 90% of current transfers (90% x 946 patients = 851 patients) and that length of stay declines to 6 days, this transfer volume would translate into 14 occupied beds *attributed to existing patients* served in AAMC's Emergency Department. Therefore, AAMC could be expected to operate a new unit at 87% occupancy with existing patient volume from its Emergency Room patients. This volume does not include any referrals from other hospitals.

This documented volume of ED transfers establishes evidence of community need *and* firm evidence that AAMC does not need to develop aggressive outreach and marketing strategies to capture market volume. Indeed, patients are already coming to AAMC for care, but AAMC unfortunately must re-route patients to another provider for acute care services.

Population-based projection model (Chart 37, page 76)
While the transfer data, by itself, demonstrates community need (946 patients) and AAMC's immediate ability to fill 14 beds (946 x 90% retention = 851 patients), AAMC prepared a more rigorous, population-based model to project volume going forward to reflect:

- Projected demographic growth
- Projected use rate decline
- Realistic market share targets, in context of
    - AAMC's market share in its service area
    - Travel time/distances to other mental health providers and AAMC as a closer alternative
    - Anticipated competition/service development by other acute care providers

The population-based use rate model was prepared based on assumptions delineated on pages 73-75, and produced the final volume projections appearing on Table I. Final discharge

projections reflect 1% annual demographic growth, steady use rate declines, and a 25% AAMC market share of adult mental health discharges within the 2-County region. With an additional 15% of out-of-area volume, total discharges were projected for the new unit in Table I:

AAMC Projected Discharges (from Table I)

	FY2019	FY2020	FY2021	FY2022	FY2023
# of Mental Health Discharges	718	879	886	892	892

Assessment: Assumptions validated

It is fair to state that the population-based model validated AAMC's premise that a 16-bed unit will operate at 90%+ occupancy, and confirmed that the current transfer volume (946 AAMC-eligible patients) serves as a reasonable indicator of projected volume.

The population-based projection is based on a 25% market share target, which is a reasonable one for AAMC in the 2-County region, and is further supported by the fact that AAMC effectively captures more than 20% share of mental health discharges through its ED, but cannot admit these patients.

AAMC also notes that both of the analyses prepared in the application - - - the examination of transfer volume and the population-based projection model - - apply a use rate reduction for inpatient psychiatric care which assumes that AAMC's new partial hospitalization and other community-based services will substitute for a significant amount of care now provided in the inpatient setting. The population-based projection model assumes that the admission rate for psychiatric services will decline by approximately 15-20% over the projection period. Therefore, the total market for inpatient psychiatric services reflects the growing demographics in this region but also reflects the declining use rate of inpatient mental health services. Market share projections have been applied to this properly-sized market that reflects the decline in use rates.

10. **Please identify what procedures are included in APR-DRG 779-790, and how the applicant included these procedures in its Need analysis.**

Applicant Response:

(A) The APR-DRG's referred to above are codes that were used prior to FY2014 to identify involuntary admissions; the HSCRC eliminated use of these APR-DRGs beginning in FY2014. Beginning in FY2014, involuntary admissions have been coded in the field of "Nature of Admission."

(B) The volume of mental health discharges documented in the application includes both voluntary and involuntary admissions across the entire time periods represented. No exclusions of involuntary admissions, as a category, were made.

(C) Based on discussion with MHCC staff, AAMC understands that the reference to "procedures" is not relevant to the intent of the question and does not need to be addressed.

(D) For further clarification of the DRG's included in the patient profile projected for AAMC's new unit, the following information is re-presented:

The total volume of transfer cases from AAMC's Emergency Room to other hospitals was sorted by DRG as the basis for projecting the DRG mix of discharges at AAMC new mental health unit. This mix of DRG cases is not defined by procedure code, but by the DRG diagnosis established at the point of discharge. This mix of DRG's includes:

DRG 750 Schizophrenia

DRG 751 Major depressive disorders and other/unspecified psychoses

DRG 753 Bipolar disorders

DRG 754 Depression exc. major depressive disorder

DRG 755 Adjustment disorders and neuroses exc. depressive diagnosis

DRG 756 Acute anxiety and delirium states

11. **What is the source of the discharges/1000 numbers on Chart 37?**

Applicant Response:

(A) Chart 37 presents the total market of **"AAMC-eligible"** mental health discharges, with "AAMC-eligible" defined by

- Age: Age 18+, only
- Discharge diagnosis: Discharges with psychiatric diagnosis defined by
  - Psychiatric DRG 750-760, or
  - Psychiatric DRG 740, **and** at least 1 day in a Psychiatric Unit
  - Postpartum/Antepartum DRG 561 or 566, ***and*** at least 1 day in a Psychiatric Unit
  - Psychiatric diagnosis code (290-319), ***and*** at least 1 or more day in an acute Psychiatric Unit
- *Excluding* primary diagnoses not expected to be served in AAMC's mental health unit:
  - Drug/alcohol psychoses (ICD 9 291-292)
  - Eating disorders (DRG 759)
  - Dementias/chronic organic/neurologic disorders (ICD 9 290-294)
  - Intellectual disorders/mental retardation (ICD 9 codes 317-319)

The source for this discharge data was the HSCRC Discharge Abstract Database.

(B) Chart 37 presents this information by County of residence for (1) Anne Arundel County residents and (2) Queen Anne's County residents. County of residence reflects the County of residence as coded in the HSCRC Discharge Abstract Database.

(C) Chart 37 documents the historical use rate - - defined by discharges per 1,000 - - for adult residents of Anne Arundel and Queen Anne's County, combined. This data is excerpted and presented below:

	Historical Experience	
	2014	2015, Annualized[2]
Adult population	451,791	456,970
Mental Health discharges		
Anne Arundel	3,249	3,360
Queen Anne's	164	172
Total, 2 Counties	3,413	3,532
Discharges per 1,000	7.55	7.73

[2] Annualized based on 9 months actual, Jan –Sept 2015

Therefore, historical discharges per 1,000 for Years 2014-2015 is purely a calculation based on published population figures and actual discharges for Years 2014-2015, **with discharge volume defined by the specific clinical cohorts that AAMC will be serving.** This approach protected against overstating AAMC's volume projections; the base market demand was limited to "AAMC-eligible" cases before applying any market share assumptions.

The source for population data was Nielsen Site Reports.

(D) AAMC projected total market volume through Year 2022 based on the assumption that inpatient use rates would decline considerably with growing reliance on the partial hospitalization program and community-based supports. The overall discharge rate is projected to decline by approximately 15% over the course of the projection period (reflecting a major decline projected for Anne Arundel County residents, but more modest decline in an already low use rate population of Queen Anne's County).

	Actual	Projected
	2014	2022
Adult population	451,791	487,679
Mental Health discharges		
Anne Arundel	3,249	2,963
Queen Anne's	164	174
Total, 2 Counties	3,413	3,137
Discharges per 1,000	7.55	6.43
% use rate decline		*(15%)*

12. **The application includes a significant amount of shelled space, perhaps as much as 35% of total construction. Staff has several questions related to that.**

    a) **The first floor shelled space is expected to be used for outpatient mental health services. Given that the program described in the application already includes outpatient and partial hospitalization, what additional outpatient services would be provided if/when this space is finished that won't be from the outset?**

    Applicant Response: In preparing a response to this question, the Applicant discovered that the narrative description of the Project in the Application incorrectly states that, in addition to the inpatient unit and the partial hospitalization program, the Project will include an "ambulatory outpatient clinic" (see Brief Description of the Project paragraph on page 8, and page 14, first full paragraph) as well as "intensive outpatient programs (see page 9, third full paragraph and page 14, second full paragraph). While these programs are potential future programs for the shell space, they are not part of the proposed project in this Application and were not included in any of the financial projections in the Application. The clinical programs that will be part of the project as proposed in the Application are limited to the inpatient psychiatric program and the partial hospitalization program.

    The AAMC Division of Mental Health and Substance Use currently offers psychiatric partial hospital services in leased space on Holiday Court in Annapolis. That program will move to the finished space on the first floor of the new building. Additionally, AAMC current offers child and adult outpatient mental health services in leased space at 2635 Riva Road, Suite 108, in Annapolis. That program is limited in its further growth by the amount of space available in our leased quarters at 2635 Riva Road. We anticipate that the adult outpatient services will eventually move into the shell space on the first floor of the new building, allowing the adult outpatient program to grow to respond to demand that already outpaces current capacity, and allowing the children's outpatient service, continuing to occupy the leased space at 2635 Riva Road by itself, also to grow to meet demand.

b) You provided the cost estimate for finishing the space, but what is the cost of constructing it?

Applicant Response:

TOTAL COST / SF EXTRAPOLATION FOR 1ST FLOOR SHELL SPACE

Total Building Area (SF)		66,572
Total Project Cost	$	16,988,237
Average Cost per SF	$	255.19
1st Floor Shell Area (SF)		5,796
1st Floor Shell Cost Estimate @ Full Build	$	1,479,058
Deduct Fit Out Costs @ $115/SF	$	(667,000)
Estimated Cost to Construct	**$**	**812,058**

This methodology is based upon determining the average cost per square foot for the project and applying the unit rate to the size of the shell space. Although the cost to construct the structure for the 1st floor shell space is estimated at $812,058, these costs are necessary as the area supports finished space above. Also, please note that this estimate includes costs that are not specifically attributable to the 1st floor shell space and thus overstates the incremental cost of constructing the 1st floor shell space. The cost to construct the 3rd floor shell space is addressed in response to Question 12e below.

c) **The third floor (shelled) is identical in size to the floor holding the proposed 16 bed unit, and specifies that its most likely use is for inpatient mental health beds, to be added within 3-5 years. Please address the future need for the beds in light of the fact that your need analysis does not approach a need for 32 beds. How will that need materialize within the specified 3-5 years?**

Applicant Response: Depending on the fate of the IMD exclusion and waivers to it that might be available, AAMC may respond to local need for inpatient mental health beds by utilizing the third floor shell space for some combination of 1) adolescent inpatient beds, 2) inpatient beds for the medically-frail or cognitively-impaired (historically called "geriatric psychiatry") population, 3) beds for other special populations such as psychotic disorders or eating disorders, or 4) incrementally additional general adult inpatient beds, Only the last category (general adult population) was considered in the need analysis for the 16-bed unit proposed in the Application.

In the absence of any relief from the IMD exclusion, AAMC may utilize this shell space to expand outpatient offerings into the areas of psychiatric intensive outpatient services for children, adolescents and adults, or into specialty outpatient programs for psychosomatic disorders (particularly psycho-oncology), obsesity with psychiatric or substance use co-morbidities, or patients with comorbid chronic pain, psychiatric disorders, and addiction.

d) A Net Present Value calculation demonstrating the cost-effectiveness of constructing the shelled space was not provided, and should be.

Applicant Response:

The Net Present Value (NPV) calculation including the cost to construct the 3rd floor shell space as part of the initial project is as follows:

		Inflated		Uninflated
Discount Rate		5.0%		5.0%
Investment	$	(16,998,237)	$	(16,998,237)
Year 1	$	203,264	$	207,197
Year 2	$	1,355,641	$	1,331,870
Year 3	$	1,465,935	$	1,410,794
Year 4	$	1,536,896	$	1,448,880
Year 5	$	1,591,918	$	1,471,467
NPV		($11,796,999)		($12,029,234)

The following is the Net Present Value calculation not including the cost to construct the 3rd floor shell space as part of the initial project and assuming the shell space is constructed in year 4:

		Inflated		Uninflated
Discount Rate		5.0%		5.0%
Investment	$	(15,468,237)	$	(15,468,237)
Year 1	$	203,264	$	207,197
Year 2	$	1,355,641	$	1,331,870
Year 3	$	1,465,935	$	1,410,794
Year 4	$	(1,143,104)	$	(1,231,120)
Year 5	$	1,591,918	$	1,471,467
NPV		($12,471,841)		($12,704,077)

Accordingly, this Net Present Value analysis demonstrates the cost effectiveness of constructing the 3rd Floor Shell Space as part of the project.

e) Provide the calculations for the MVS analysis referenced on p. 78.

Applicant Response:

FLOOR AREA UNIT COSTS

		UNIT RATE FULL BUILD	ADJUSTED UNIT RATE FOR SHELL		
9.	Excavation	$ 3.58	$ -		
10.	Foundation	$ 3.58	$ -		
11.	Frame	$ 20.24	$ 20.24		
12.	Floor Structure	$ 12.08	$ 12.08		
13.	Floor Cover	$ 7.54	$ -		
14.	Ceiling	$ 3.67	$ -		
15.	Interior Construction	$ 50.77	$ -		
16.	Plumbing	$ 8.14	$ 4.07		
17.	Sprinklers	$ 2.59	$ 1.30		
18.	HVAC	$ 13.21	$ 7.93		
19.	Electrical	$ 17.38	$ 8.69		
TOTAL FLOOR AREA UNIT COST		$ 142.78	**$ 54.30**		
Floor area for 3rd floor shell (Square Feet)			16,688		
				$	906,175
WALL UNIT COSTS					
21.	Exterior Walls		$ 28.50		
Area of Perimeter Walls (Linear Feet)			14,914		
				$	425,055
ADJUSTMENTS					
	Final Multiplier		1.09	$	119,811
LUMP SUM					
	Elevators		$ 60,000		
	Stairs		$ 20,000		
				$	80,000
COST OF CONSTRUCTING 3RD FLOOR SHELL				**$**	**1,531,040**

Availability of More Cost Effective Alternatives

13. Is the "Greenfield" alternative shown in Chart 38 the same as "Option 4: Redevelop Existing Site" described on p. 83?

Applicant Response: Yes. The column was mis-labelled on the chart and is corrected below.

	Inpatient Psych CON Decision Matrix	Relative Weight	Main Hospital		Riva Road Property		Redevelop Existing Site	
	Key Criteria		Rank	RxW	Rank	RxW	Rank	RxW
Quality	Program Quality	13	3	39	5	65	3	39
	QBR Impact	11	1	11	5	55	5	55
	Risk Management/ Patient Safety	12	1	12	5	60	5	60
Community	Patient Care Access	3	5	15	3	9	1	3
Workforce	Staffing	9	5	45	3	27	1	9
	Staff Satisfaction/Engagement	5	3	15	3	15	3	15
	Support Services	2	5	10	1	2	1	2
Growth	Capacity for Growth	6	1	6	3	18	5	30
	Partnering Opportunities	1	1	1	1	1	5	5
Finance	Cost (Building Cost)	7	5	35	5	35	1	7
	Operating Margin	10	5	50	5	50	3	30
	Life Cycle Costs	8	5	40	5	40	1	8
	Reimbursement (GBR)	4	1	4	3	12	5	20
	TOTAL		283		389		283	

Best outcome = 5
Average outcome, acceptable outcome = 3
Least desirable outcome = 1

Impact on Existing Providers and Health Care Delivery System

14. **Please explain the number of transfers reported on Chart 5 on p. 37 with the lower numbers indicated on Chart 39 on p. 93.**

Applicant Response: Chart 5 (page 37) documents the total number of adult transfers from AAMC's Emergency Department to Acute Psychiatric Units in Maryland hospital who would have been eligible to be admitted to an acute mental health unit at AAMC (these patients are referred to as "AAMC eligible patients"). These 946 cases were actual patients documented to have been transferred to the hospitals listed in Chart 5.

Chart 39 (page 93) makes use of the very same database of actual transfers from AAMC (946 patients), but excludes Prince George's County residents from the projected patient base to establish a more conservative base of 884 transfers. These figures do not represent the final volume projections for AAMC's new unit; these figures represent the patient population used to prepare resource utilization and financial projections. AAMC expects that 85% of its volume will be drawn from the 2 County service area (Anne Arundel Medical Center and Queen Anne's County). Therefore, the clinical profiles and financial projections were prepared on the basis of this dominant patient base from the 2 County region to be most representative for a cost profile.

Stated simply:

- Chart 5 (page 37) documents the total number of AAMC eligible transfers that occurred in FY2015 (946 adult patients)
- Chart 39 (page 93) documents the patient population that served as the basis for preparing the DRG mix/resource utilization/cost profile for the new unit at AAMC
    - With the assumption that Prince George's County residents will increasingly be served by hospitals within Prince George's County

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Applicant's responses to the May 3, 2016 completeness questions are true and correct to the best of my knowledge, information and belief.

5/13/16
Date

Miriam Suldan
Senior Managing Consultant
Berkeley Research Group, LLC

Anne Arundel Medical Center

2001 Medical Parkway
Annapolis, Md. 21401
443-481-1000
TDD: 443-481-1235
askAAMC.org

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Applicant's responses to the May 3, 2016 completeness questions are true and correct to the best of my knowledge, information and belief.

5/13/16
Date

Victoria W. Bayless
President & Chief Executive Officer
Anne Arundel Medical Center

Anne Arundel Medical Center

2001 Medical Parkway
Annapolis, Md. 21401
443-481-1000
TDD: 443-481-1235
askAAMC.org

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Applicant's responses to the May 3, 2016 completeness questions are true and correct to the best of my knowledge, information and belief.

5/13/16
Date

Lucas Klock
Director, Capital Projects
Anne Arundel Medical Center

Anne Arundel Medical Center

2001 Medical Parkway
Annapolis, Md. 21401
443-481-1000
TDD: 443-481-1235
askAAMC.org

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Applicant's responses to the May 3, 2016 completeness questions are true and correct to the best of my knowledge, information and belief.

5/13/16
Date

Catherine Yurkon
Vice President of Finance
Anne Arundel Medical Center

List of Exhibits to Responses to May 3, 2016 Completeness Questions

Exhibit 17 (revised) – Discharge Planning

Exhibit 18 – Organizational Chart

Exhibit 19 – Oversized Drawings

Exhibit 20 – Location maps

Exhibit 21—DHMH Letter of Acknowledgement

	Discharge Planning for Inpatient Psychiatric Services
Dates Previously Reviewed/Revised: **Newly Reviewed By:** **Approval Date:** TBD **Effective Date:** TBD	**Owner:** Reviewed (date & initials):
Approver Title Approval Signature	

Scope: Discharge from Inpatient Psychiatric Unit

Policy Statement: The purpose of this policy is to ensure elements important to the discharge/aftercare planning phase of patient care are developed and implemented consistently. Potential discharge needs are assessed upon admission. A comprehensive discharge planning assessment is documented by a member of the Care Management team on patients with a potential discharge need. The discharge plan is developed, in cooperation with the patient and/or family and the interdisciplinary team members, in order to implement a safe and appropriate discharge. Reassessment of the patient's discharge need(s) is done based on changes in the patient's condition, availability of resources, patient/family reported needs and/or interdisciplinary team recommendations.

Definitions:

RN – Actively communicates with patient, family, and members of the clinical team, as appropriate to provide a comprehensive, and coordinated discharge plan.

Social Worker – Actively communicates with patient, family, and members of the clinical team, as appropriate, to provide a comprehensive and coordinated discharge plan. The Social Worker connects patients and their families to appropriate community resources and provide psychosocial and emotional support to the patient and/or family as needed.

Procedure:

Before discharging patients from the inpatient psychiatric unit, the staff must complete the following:

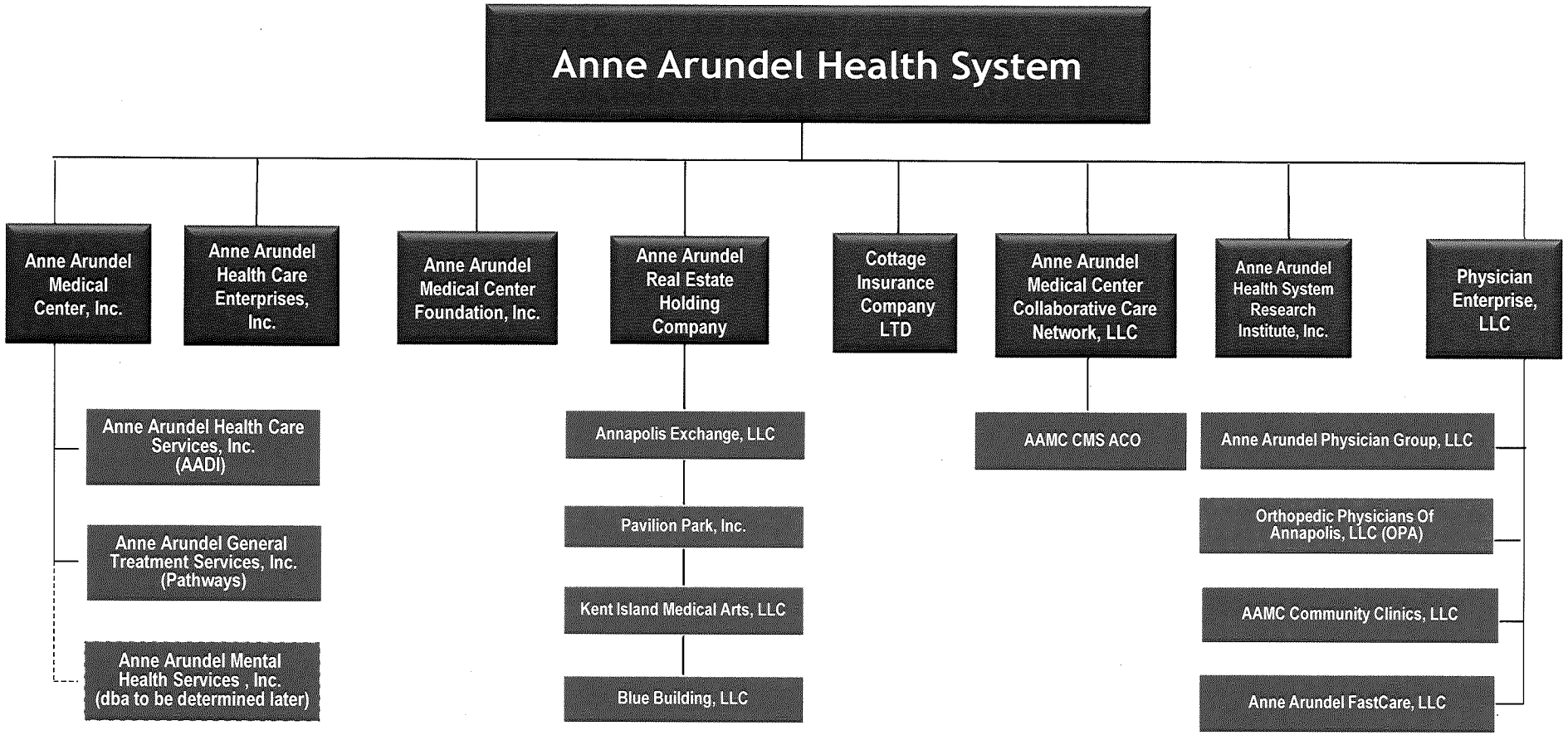
1. The RN verifies the presence of a valid discharge order from the physician.
2. The RN asks the patient to complete the Suicide Risk Assessment form and reviews the patient's responses with the patient.
3. The RN completes the top half of the Discharge Checklist and signs and dates that part to indicate that tasks have been completed. The PC completes the bottom half of the form and signs and dates it. The patient signs the form indicating that the patient has received their belongings. (The Discharge Checklist is filed for future reference and is discarded after 3 months.)
4. The RN checks the locked medication storage cabinet, the patient's medication drawer, and the Pyxis for patient owned medications. The RN confirms the medications found with the Patient Own Medication Control Form, returns the medications to the patient. The RN and the patient sign the Patient Own Medication Control Form where the discharge is indicated.
5. Staff will Contact Security for any items stored in the safe.

6. The physician completes the medication reconciliation and After- Visit Summary. The physician lists medications, doses, route, and frequency for medications patient is to continue, including medications patient was taking at home before admission. The physician lists the medications the patient is to stop taking, including any the patient was taking at home before admission that are no longer pertinent to the patient's care. The physician completes and prints prescriptions.
7. The Social Worker arranges for and enters the aftercare appointments.
8. The RN reviews the After Visit Summary with the patient, making certain that the patient can read and understand the information. The RN will:
    a. Clarify any questions about medications and provide handouts as needed. Give the prescriptions, if any, to the patient.
    b. Be sure the patient is clear about the aftercare appointments.
    c. Review any medically oriented instructions with patient, such as dressings, etc.
9. The RN assesses that the patient understands the discharge instructions by asking the patient and/or the family to provide feedback in their own words.
10. The RN will have the patient sign the discharge summary, and ensure patient and/or family member receives a copy of the discharge summary.
11. The RN documents the discharge summary in the electronic medical record and enters a note indicating the patient's condition at the time of discharge.

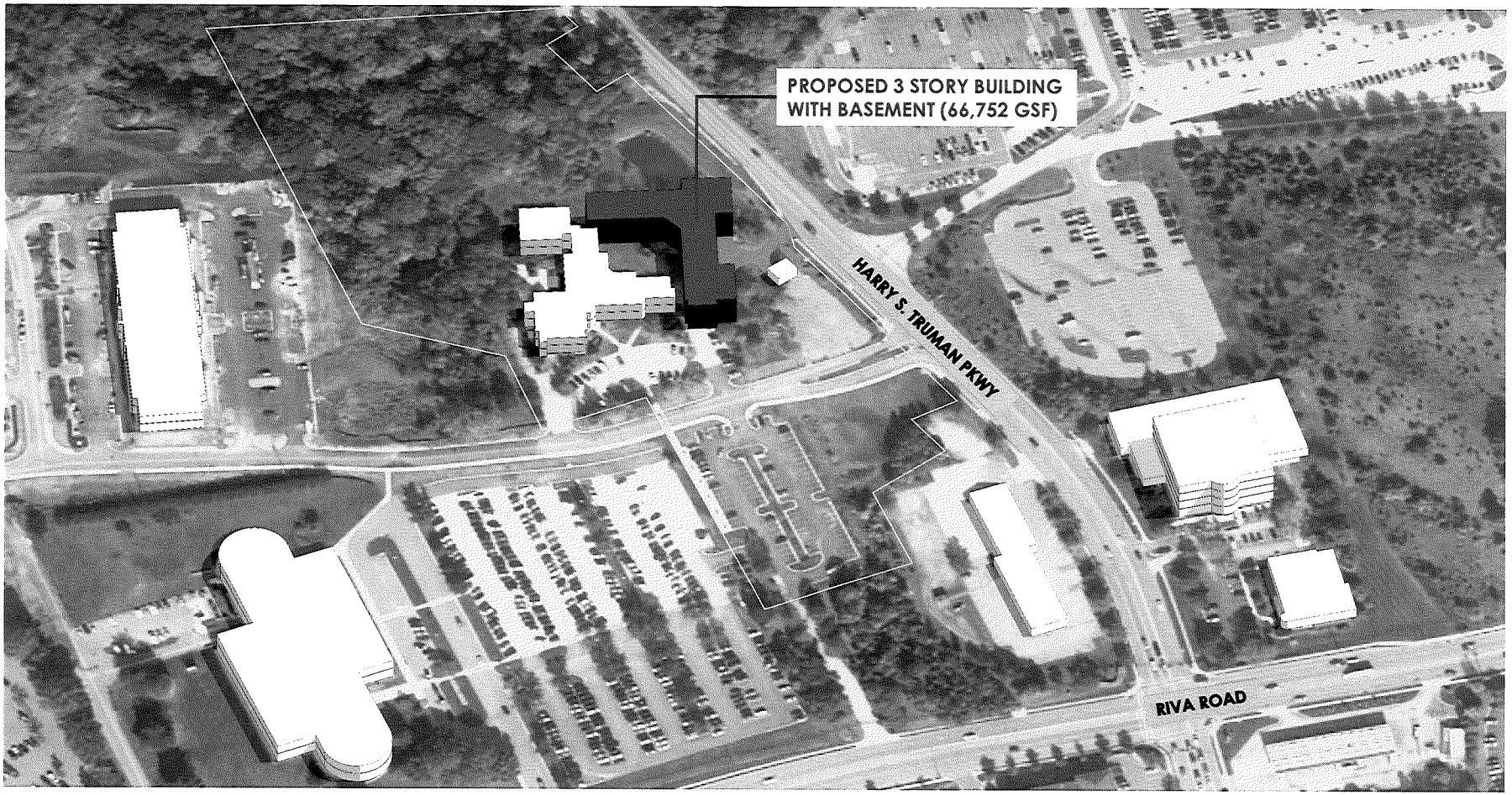
References: Joint Commission E-dition. (2016) Hospital, Accreditation, Provision of Care, Treatment and Services. https://e-dition.jcrinc.com/MainContent.aspx

Cross References:
NAP12.3.02 - Discharge of a Patient

Corporate Structure



OVERSIZED DRAWINGS



MENTAL HEALTH HOSPITAL

N

Anne Arundel Medical Center

CRGoodmanAssociates
ARCHITECTURE ▪ INTERIOR DESIGN ▪ PLANNING

STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van T. Mitchell, Secretary

May 9, 2016

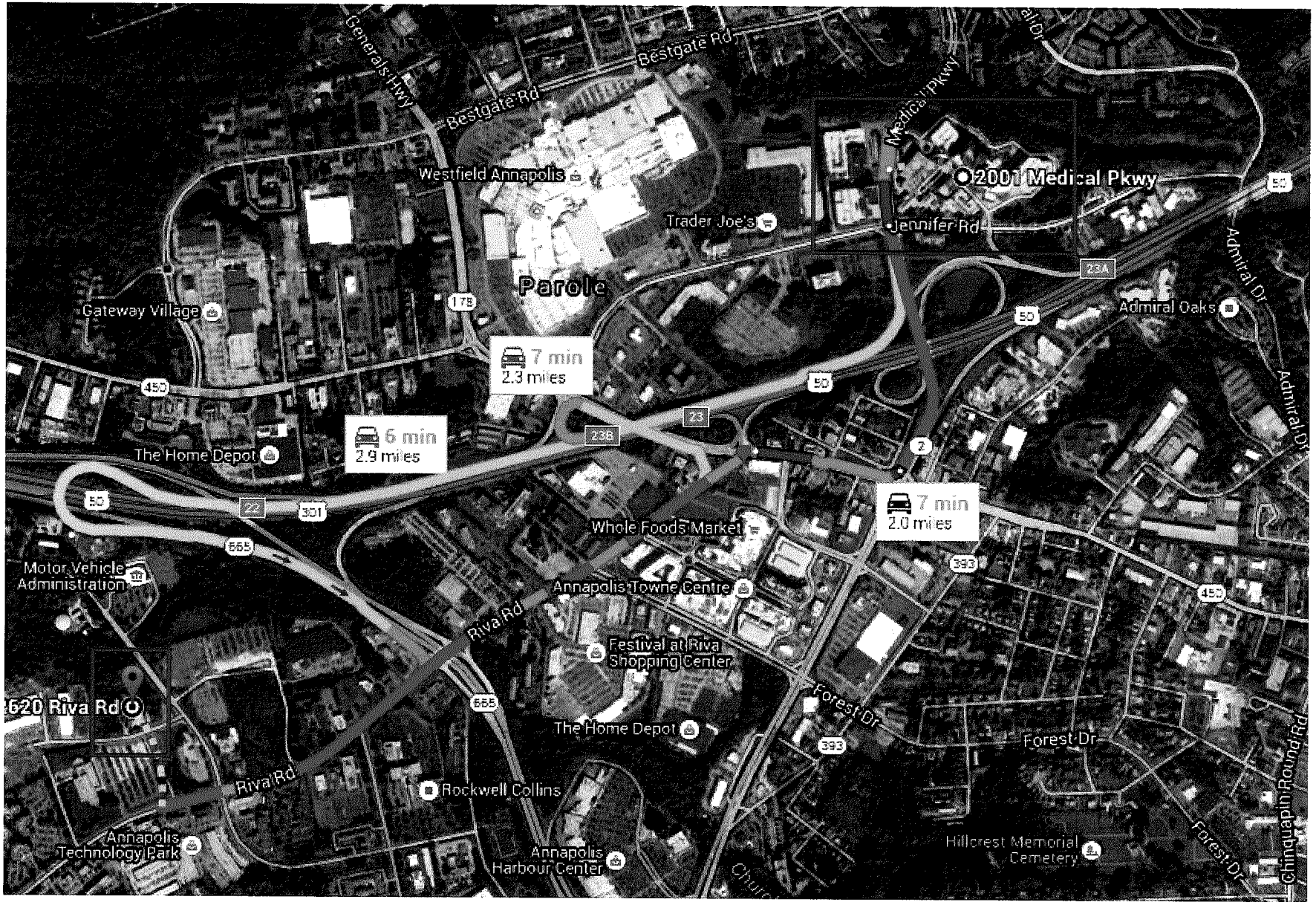
Kevin McDonald
Chief, Certificate of Need Division
Center for Health Care Facilities, Planning and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore MD 21210

Dear Mr. McDonald:

The Department of Health and Mental Hygiene hereby acknowledges notification by Anne Arundel Medical Center (AAMC) that it is seeking a Certificate of Need to establish a new mental health hospital for adults with 16 inpatient psychiatric beds on the site in Annapolis on which AAMC currently operates Pathways, a substance use and co-occurring disorders residential and outpatient treatment facility. AAMC has provided me with the executive summary of the project from its Certificate of Need Application.

Sincerely,

Van T. Mitchell
Secretary


Generals Hwy
Bestgate Rd
Bestgate Rd
Medical Pkwy
Westfield Annapolis
2001 Medical Pkwy
Trader Joe's
Jennifer Rd
Parole
Gateway Village
Admiral Oaks
Admiral Dr
7 min
2.3 miles
6 min
2.9 miles
7 min
2.0 miles
The Home Depot
Whole Foods Market
Motor Vehicle Administration
Annapolis Towne Centre
Riva Rd
Festival at Riva Shopping Center
2620 Riva Rd
The Home Depot
Forest Dr
Rockwell Collins
Annapolis Technology Park
Annapolis Harbour Center
Hillcrest Memorial Cemetery
Chinquapin Round Rd